MYOFASCIAL therapy center

Patient History--Please complete front and back before your first therapy visit.

Name _____ Date _____

When did your current problem start? _____

Please describe how your symptoms first started: _____

_____

Since they started, are your symptoms: better / worse / same

Have you had any medical tests for this problem? Please list results:

- ☐ MRI
- ☐ CT Scan
- ☐ X-ray
- ☐ EMG
- ☐ Other _____

_____

What treatment have you received for this problem? _____

_____

_____

_____

Was it helpful? yes no

Have you taken any of the following **OVER THE COUNTER** medications in the last week?

Aspirin	Decongestants	Laxatives	Advil / Motrin / Ibuprofen
Tylenol	Antihistamines	Antacids	

Vitamins / minerals / herbs _____

Other _____

_____

Please list any **PRESCRIPTION** medications you are currently taking and the dosage: (please use separate page if necessary.)

_____

_____

_____

_____

Do you smoke cigarettes? No Yes # of packs a day?

What is your occupation? _____

What is your current work status? full duty / modified duty / off work since_____ / n/a

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Have you recently had

Yes	No	Unexplained weight loss / gain
Yes	No	Fever / chills / night sweats
Yes	No	Nausea / vomiting
Yes	No	Headaches / dizziness / vertigo / visual disturbances
Yes	No	Fatigue
Yes	No	Weakness
Yes	No	Numbness or tingling
Yes	No	Difficulty with urination/bowel movements
Yes	No	Increase in symptoms when you cough or sneeze

Please indicate any of the following conditions with which you have been diagnosed:

- ☐ Heart Problems
- ☐ Circulation problems
- ☐ High blood pressure
- ☐ Asthma
- ☐ Emphysema / Bronchitis
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Blood clots
- ☐ Allergy
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Epilepsy / seizures
- ☐ Rheumatoid arthritis
- ☐ Other arthritic conditions (Gout, Psoriatic)
- ☐ Scoliosis
- ☐ Hernia
- ☐ Osteoporosis
- ☐ Head trauma
- ☐ Cancer, If YES, describe what kind _____
- ☐ Other _____

_____

Women, is there any possiblity that you are pregnant? yes no

Please list any surgeries (inpatient or outpatient), or conditions for which you have been hospitalized

_____

_____

_____

_____

Please list any scars and their locations: _____

_____

_____

Do you use any special supports?

- ☐ back cushion, neck cushion
- ☐ back brace, corset
- ☐ splints
- ☐ orthodics
- ☐ other kind of brace / support for any body part _____